(b) The FEHB plan's benefit payment for physician services under this subpart is determined by taking the lower of the following amounts:

(1) The amount determined by the FEHB plan, which is equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians (the amount payable before the Medicare deductible and coinsurance are applied); or

(2) The actual billed charges; and

(3) Reducing the lower amount by any FEHB plan deductible, coinsurance, or copayment that is the responsibility of the retired enrolled individual.

[58 FR 38663, July 20, 1993, as amended at 60 FR 26668, May 18, 1995]

§ 890.905 Limits on inpatient hospital and physician charges.

(a) Hospitals may not collect from FEHB plans and retired enrolled individuals for inpatient hospital services more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) Medicare participating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) Medicare nonparticipating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995; 60 FR 28019, May 26, 1995]

§ 890.906 Retired enrolled individuals coinsurance payments.

(a) A retired enrolled individual's coinsurance responsibility for inpatient hospital services is calculated in accordance with the plan's contractual benefit structure and is based on the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A retired enrolled individual's coinsurance responsibility for physician services is calculated in accordance with the plan's contractual benefit structure and is based on the lower of the actual charges or the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians.

[60 FR 26668, May 18, 1995]

§ 890.907 Effective dates.

(a) The limitation specified in this subpart applies to inpatient hospital admissions commencing on or after January 1, 1992.

(b) The limitation specified in this subpart applies to physician services supplied on or after January 1, 1995.

[60 FR 26668, May 18, 1995]

§ 890.908 Notification of HHS.

An FEHB plan, under the oversight of OPM, will notify the Secretary of HHS, or the Secretary's designee, if the plan finds that:

(a) A hospital knowingly and willfully collects, on a repeated basis, more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A Medicare participating physician or supplier knowingly and willfully collects, on a repeated basis, more than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) A Medicare nonparticipating physician or supplier knowingly and willfully charges, on a repeated basis, more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995]

§ 890.909 End-of-year settlements.

Neither OPM, nor the FEHB plans, will perform end-of-year settlements with, or make retroactive adjustments as a result of retroactive changes in the Medicare payment calculation information to, hospital providers who

have received FEHB benefit payments under this subpart.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

§ 890.910 Provider information.

The hospital provider information used to calculate the amount equivalent to the Medicare part A payment will be updated on an annual basis.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

Subpart J—Debarments, Civil Monetary Penalties and Assessments Imposed Against Providers

SOURCE: 54 FR 43940, Oct. 30, 1989, unless otherwise noted.

§ 890.1001 [Reserved]

§ 890.1002 Definitions.

(a) For the purposes of this subpart, the terms *convicted* and *provider* have the meanings set forth in section 8902a of title 5, United States Code.

(b) *Debarment* means that services or supplies furnished by a specific provider will no longer be reimbursed by the various carriers or health plans under title 5, United States Code, or this part.

(c) *Sanction* means any of the three penalties provided by section 8902a of title 5, United States Code, for the offenses cited therein. The three penalties are debarment, civil monetary penalties of not more than $10,000 for any item or service involved, and assessments of not more than twice the amount claimed for each such item or service.

§ 890.1003 Standards for OPM determinations of excessive charges, overprescribing, and services or supplies of a poor quality in connection with claims presented under this chapter.

(a) *Basis for sanctions.* Section 8902a(c) of title 5, United States Code, provides OPM the authority to impose sanctions against health care providers for cited offenses against the FEHB Program.

(b) *Standards.* (1) In making a determination that a provider has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, OPM may rely, in part, upon a statistical sampling of previous claims and requests for payment filed by that provider and obtained either from FEHB carrier files, other Government programs, private sector insurance sources or from the provider's own records. OPM shall take into consideration whether such charges deemed to be excessive are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is acceptable medical practice to make an extra charge in such case.

(2) In making a determination that a provider has charged for health care services or supplies which are substantially in excess of the needs of the insured or which are of a quality that fails to meet professionally recognized standards for such services or supplies, OPM may rely, in part, upon reports, including sanction reports, from the following sources:

(i) The Professional Standards Review Organization or the Peer Review Organization for the area served by the provider;

(ii) State or local licensing or certification authorities;

(iii) Peer review committees of health plan carriers;

(iv) State or local professional societies; or

(v) Other sources deemed appropriate by OPM.

§ 890.1004 Standards for determining either the period of debarment or the amount of civil monetary penalties or assessments.

(a) In determining either the period of debarment or the amount of any civil monetary penalty or assessment, OPM shall take into account the specifics of section 8902a(e) of title 5, United States Code; i.e., the nature of